EMSC /MIMPEC Advisory Committee Meeting
Video Conference/In-person/Telephone
June 12, 2013
11.30 AM- 1:00 PM

Technical difficulties

No official Roll Call taken:

Helena

Bette Hall-Munger, Child Advocate
Robyn VanHemelryck, Family Representative
Kimberly Hardwick, RN- CSHCN
Lori Rowe, FIMCR State Coordinator
Bobbi Perkins, Injury Prevention Coordinator
Carol Kussman, RN- Trauma Coordinator
Robin Suzor, EMSC Program Manager, MT DPHHS
Gail Hatch, EMS&T Data Analyst,

Conference Call

Shari Graham, NREMT-P, DPHHS EMS System Manager
Joseph Hansen, Family Representative (IRREC Intermountain Regional EMSC Coordinating Council)
Corporal Kurt Sager, Montana Highway Patrol

Billings (MIMPEC)

Kassie Runsabove
Kristi Conroy
Dr. Salerno
Chuck Bratsky
Doris Barta
Stacy Stellflug
Erin Bills
Lorna Dyk
Carol Beam
Heather Fink
Tony Fisher

Absent

Karl Rosston, Suicide Prevention Coordinator, MT DPHHS
Dayle Perrin, Hospital Preparedness Coordinator, MT DPHHS
Chris Ouellette, RN
MT DOT Representative
MT School nurses Association representative
Tara Zoanni - Billings Clinic Nurse Rep

Minutes:

MIMPEC Report

Kassie gave a work plan update.
Showed pictures and gave updates on visits and mock codes
Year 1 activities; Year two goals; gave short synopsis on SPROC for new members
Recent site visits to Colstrip and Hardin performing mock codes and also Broselow Bag check as well as Broselow Tape training. Colstrip working towards Level IV certification. Physicians and all staff are PALS certified.
MIMPEC is considering a name change to "Child Ready" to make it more recognizable.
In working with IHS, it was decided to stay within the walls of IHS medical community rather than reach out in the tribal community.
Jim DeTienne gave a detailed explanation of SPROC for the benefit of this new combined council

EMSC

1. Federally funded from Health Resources and Services Administration **HRSA** is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. The Maternal and Child Health Bureau **(MCHB**) improves the health of all mothers, children and their families; **EMSC** is for the integration of pediatric priorities in all components of Emergency Medical Services (EMS.)

   This is the first official combined MIMPEC and EMSC Advisory Council meeting. EMSC Advisory Committee-guiding and providing oversight to the EMS&Trauma Section to improve the outcomes in the critically ill and injured throughout the continuum of injury prevention, emergency response, prehospital care, hospital care, interfacility transport through rehabilitation.

Pediatric Readiness Project –National multi-phase on-going quality improvement initiative to ensure that Emergency Departments (ED are ready to care for children. Report on Pediatric Readiness Project initial report, report 85% response rate = 51/60 MT hospitals responded. A full report will be given at next meeting. Discussed the Guidelines for Care of Children in the ED as a basis for the assessment; and collaborative effort the American Academy of Pediatrics (AAP), The American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA). Copies of Guidelines

distributed in packets. Montana's initial report

Current National Results

Basic Statistics from Completed Assessments

Annual ED Pediatric Patient Volume	Hospitals w/EDs	Average Score	Median Score	Minimum Score	Maximum Score
Low Volume (<1800 patients)	1,353	62	61	22	100
Medium Volume (1800-4999 patients)	1,043	70	70	29	100
Medium to High Volume (5000-9999 patients)	594	74	75	31	100
High Volume (>=10000 patients)	503	85	90	36	100
Grand Total	**3,493**	**70**	**70**	**22**	**100**

Screen shot taken 6/13/2013

Montana Results

Annual ED Pediatric Patient Volume	Hospitals	Average Score	Minimum Score	Maximum Score
Low Volume (<1800 patients)	36	54.7	27	82
Medium Volume (1800-4999 patients)	12	63.9	44	97
Medium to High Volume (5000-9999 patients)	2	N/A*	N/A*	N/A*
High Volume (>=10000 patients)	1	N/A*	N/A*	N/A*
Grand Total	**51**	**57.5**	**27**	**97**

** Fewer than 5 Hospitals*

Performance report (2012-2013) EMSC: gave copies of the MCHB Performance Measure Report submitted to the HRSA; discussed each Performance Measure 7-41 in regards to what, how MT scored and the measures that are part each.
#7-Degree to which MCHB funded programs ensures family, youth, and consumer participation in program and policy activities.
#10 Degree to which MCHB Funded programs have incorporated cultural and linguistic competency elements into their policies, guidelines, contracts and training
#24-Degree to which MCHB funded initiative contributes to infrastructure development through core public health assessments, policy development and assurance functions.
#33-Degree to which MCHB funded initiative work to promote sustainability of their program or imitative beyond the life of MCHB funding
#41-Degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations

Went into more depth on EMSC performance measures 71-80 and the importance of each; citing the importance if each

#71-% of prehospital providers that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility- EMS providers may not have the expertise to treat pediatric patients and need access 24/7 via telephone/radio to a higher level medical provider who can provide real time patient care advice
#72-% of prehospital provider agencies in the state that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility-Assists in the standardization of pediatric patient care for the EMS providers based on current pediatric clinical recommendations and evidence-based guidelines (written protocols/guidelines available)
#73- % of patient care units in the state that have essential pediatric equipment and supplies as outlined in the national guidelines-EMS provider must have the appropriate sized-equipment and supplies to care for ill or injured children to achieve optimal pediatric patient outcomes

#74- % of hospitals recognized through a statewide, standardized system that are able to stabilize and/or manage pediatric medical emergencies-Hospital recognition for pediatric medical emergencies; Facilitates EMS transfer of children to appropriate levels of resources

(**MT EMS System**-approximate 248 EMS Services- 99 non-transport; 136 ground ambulances; 6 fixed wing; 5 rotor wing services with 82 BLS; 2 Intermediate; 39 Paramedic; 125 BLS but authorized to provide ALS with appropriate available staff. 53% of MT EMS are volunteers)

#75- % of hospitals recognized through a statewide system that are able to stabilize and/or manage pediatric medical emergencies- Standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care=progress toward developing a trauma recognition system according to a 0-5 scale

#76- % of hospitals in the state that have written interfacility transfer guidelines that cover pediatric patients and that include pre-defined components of transfer- to help assure that children receive optimal care, timely transfer to a specialty care centers is essential; better coordination through inter-facility transfer guidelines.

#77- % of hospitals in the state that have written interfacility transfer agreements that cover pediatric patients- defined process for initiation of transfer, roles and responsibilities of each aspect, and the process for selecting the appropriate care. (need to be specific to pediatric patients)

#78- the adoption of requirement by the state for pediatric emergency education for license/certification renewal of BLS/ALD providers- process for selecting the appropriately staffed transport service to match the patient's level of care required, equipment, etc. process for transfer of patient- sufficient numbers of pediatric patients to ensure skills necessary; continuing education helps to ensure prehospital providers are ready to take care of a pediatric patient; Plan for transfer of medical record; transport consent; personal belongings, provision of families

#79 Degree to which the state has established permanence of EMSC in the state EMS system by establishing and EMSC Advisory Committee, incorporating pediatric representation on the EMS Board and hiring a full-time EMSC Manager- dedicated EMSC Advisory Committee with core members and full-time Program Manager. Job of EMSC Adv Committee is to advise the EMSC on how/why/when and to help increase the Performance measures across the spectrum. Must meet 4 times a year, have pediatric representation.

#80-Degree to which states have established permanence of EMSC in the state EMS system by integrating EMSC priorities into statues/regulations- Integration of the EMSC priorities into mandates will help ensure pediatric medical care issues and or deficiencies are being address for the long-term; across the continuum including prevention of injuries and coordinated care in their communities.

Emergency Medical Dispatch Short discussion on the new manual- EMSC funds used . Will go into further detail in next meeting

EMSC Connection- monthly electronic publication for pediatric information, archived on the new updated web page; anyone interested may submit articles for distribution.

Next meeting discuss ideas on how to increase Performance measures and increase awareness of pediatric issues and how we can continue to improve the continuum of care for pediatrics.

The next meeting will be held in **August 29 times to be determined**. This follows a federal site visit in Billings and site visits to Crow Hospital, Hardin EMS (?) on August 28, 2013.

Video conferencing and conference call format will be available in Helena, C209.